WELCOME TO DR. WARNOCK'S OFFICE

Name____ Date_________________

Age_______ Sex_______ Date of Birth_____/_____/_______ Height__________ Weight__________

Pharmacy Name/ Location:_______________________________ Pharmacy Phone #______________

Have you or a family member been seen by Dr. Warnock?
_____Yes _____No

Who referred you to Dr. Warnock? Circle Below

Emergency Room Physician Internet

Insurance Friend Other

If other please list:

____

The main reason for my visit today is:

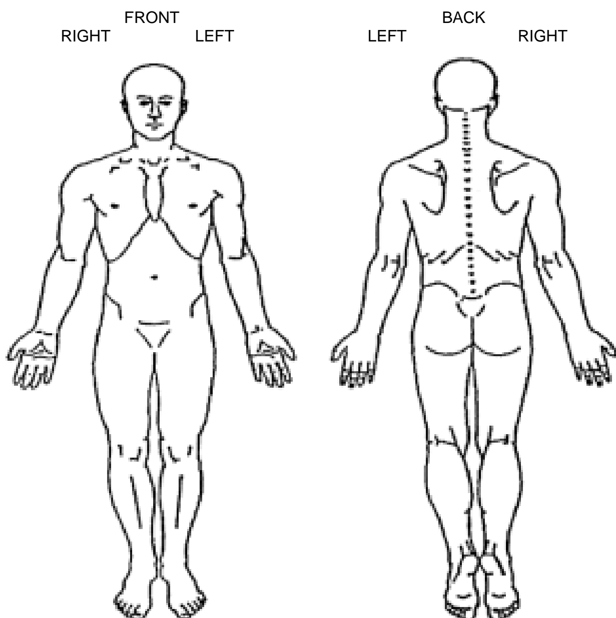
____

____

Pain Level on a Scale of 1-10 ______

My pain/injury is located: ____Right ____Left ____Both

Please circle the area where you hurt.



The date my injury/symptoms started was:

____

I have had this pain for how long:

______Days ______Months ______Years

Is this a work related injury?

____Yes ____No

Describe how your injury occurred: Fall, etc.

____

____

The pain is worse when I:

____

____

The pain is better when I:

____

____

I have had the following treatment(s) for this problem:

_____ Medication
_____ Injections
_____ Physical Therapy
_____ X-rays
_____ MRI
_____ Surgery

For this problem I have seen:

_____ Primary Care Physician
_____ ER Doctor
_____ Chiropractor
_____ Trainer
_____ Work Doctor
_____ Other ___________________________

Medications

I take the following Medications:

____

____

____

Do you take Blood Thinners? Yes / No

Allergies

I am allergic to the following:

_____ X-ray dye
_____ Iodine
_____ Shell Fish
_____ Penicillin
_____ Codeine
_____ Medications (Please List)

____

Medical History

List your Current medical conditions:

____

____

____

Are you a Diabetic? Yes / No

Do you take Insulin? Yes / No

Are Immunizations up to date? Yes / No

Is Flu Vaccination up to date? Yes / No

Surgical History

Please list all prior surgeries:

____

____

____

Social History

Occupation ___________________________________

Marital status:
_____ Single _____ Divorced
_____ Married _____ Widowed

Tobacco: How Often:
_____ Yes ______ Per Day
_____ No ______ Other

Alcohol:
_______ Never
_______ Social
List type and amount per week ____________________

Family History

List of diseases that run in your family:

_____ High Blood Pressure
_____ Diabetes
_____ Heart Problems
_____ Arthritis
_____ Cancer
_____ Gout

Ethnicity ______________________________________

Please circle the following, describing any symptoms you may have:

Fever	Loose Teeth
Chest Pain	Angina
Skin Infections	Rashes
Cracked teeth	Weakness
Mouth/Tooth Infection	Gout
Head or eye problems	Bleeding
Difficulty breathing	Depression
Difficulty urinating	Anxiety
Infections	Hot flashes
Irregular menstrual cycles	Clotting Disorder
Numbness/Tingling	